

UNIVERSITY OF MARYLAND
UNIVERSITY HEALTH CENTER

Periodic Asbestos Questionnaire

Name: _____ Social Security Number: _____ Date: _____
Home Address: _____ Dept: _____
Position: _____ Supervisor: _____ Home Phone: _____
Work Phone: _____ Work E-mail Address: _____ Date of birth: _____

Patient Information:

- A) Are you currently being treated by a doctor for any illness or injury?
Yes No If yes please list: _____
- B) Are you currently taking any prescriptions, non-prescriptions, or herbal medications?
Yes No If yes, list medicines: _____

- C) If you have seen a doctor in the past 6 weeks, state why: _____

- D) List any food, drug, or chemical allergies you have: _____
- E) Marital Status: Single Married Widowed Separated/Divorced
- F) Are you in the Asbestos Program? Yes No
- G) Are you in the Voluntary Asbestos Program? Yes No
- H) Do you wear a respirator for any purpose at work? Yes No
What kind? _____ and for what purpose? _____

Occupational History:

1. In the past year, did you work full time (30 hours per week or more) for 6 months or more? Yes No
- If yes to 1:
- B) In the past year, did you work in a dusty job? Yes No Doesn't apply
- C) Was dust exposure: Mild Moderate Severe
- D) In the past year, were you exposed to gas or chemical fumes in your work? Yes No
- E) Was exposure: Mild Moderate Severe
- F) In the past year, what was your:
1. Job/occupation? _____
2. Position/job title? _____

Recent Medical History:

1. Do you consider yourself to be in good health? Yes No
- If no, state reason _____
2. In the past year, have you developed:
- | | | | | | |
|----------------|------------------------------|-----------------------------|-----------------|------------------------------|-----------------------------|
| Epilepsy | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Rheumatic fever | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Kidney disease | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Bladder disease | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Diabetes | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Jaundice | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Cancer | Yes <input type="checkbox"/> | No <input type="checkbox"/> | | | |

Chest colds and chest illnesses:

1. If you get a cold, does it "usually" go to your chest? (usually means more than 1/2 the time) Yes No Don't get colds
2. During the past year, have you had any chest illnesses that have kept you off work, indoors at home, or in bed? Yes No Doesn't apply

If yes to 2:

B) Did you produce phlegm with any of these chest illnesses? Yes No Doesn't apply

C) In the past year, how many such illnesses with (increased) phlegm did you have which lasted a week or more? Number of illnesses _____ No such illnesses

Respiratory system:

In the past year, have you had:

	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Further comment if answered yes
Asthma	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
Bronchitis	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
Hay fever	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
Other allergies	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
Pneumonia	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
Tuberculosis	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
Chest surgery	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
Other lung problems	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
Heart disease	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____

Do you have:

	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Further comment if answered yes
Frequent colds	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
Chronic cough	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
Shortness of breath when walking or climbing 1 flight of stairs	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____

Do you:

Wheeze	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Cough up phlegm	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Smoke cigarettes	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Packs per day _____ How many years _____

I understand that this physical examination is not designed, nor intended, to replace a regular physical examination, or routine medical care, by my private physician. I understand that this examination and all subsequent examinations are highly specific to evaluate my ability to perform certain tasks noted in my job description. This examination will not cover all aspects of a full physical examination.

Signature _____ Date _____